J: Thank you for being willing to participate in the interview today. Please remember that you are not required to answer any question that you are uncomfortable with. The purpose of this project is to gather the history and evolution of occupational therapy practice in North Dakota and Wyoming through life histories of individuals who have been influential in developing OT in these two states and/or at the national level. Do you have any questions before we begin?

M: No.

J: So just one quick demographic question before we get started would be umm, just can you tell us a little about your involvement in organizations such as volunteer positions, leadership positions in state or national OT organizations?

M: Um I suppose not long after I started here at the rehab um, I thought it would be wise to get involved in the ND OT association and I was surprised that there wasn't a lot of activity or membership here. Um and not knowing a lot about it just kind of dived into it. And um as that goes shortly was the Red River district chair um, and then um proceeded to kind of stay on that board like over 20 years over a number of different offices and what not. Um, I found it helpful to network and get to know other OT's in the state and to know what was um kind of going on in the profession. I guess. Um, so because of that then um as ND state president went to national conference got to meet some of those other um leaders in other parts of the country who really had probably different OT kind of experiences and that's always helpful to learn from. And other professional organizational kind of things um I have to think about that a little bit. You know. So currently I'm the chair of the practice board.

J: Okay.

M: Yep, and um and it was always interesting on the kind of membership side which is the association side to understand how the practice board worked. Um and I think there is more

issues for the practice board of late and over the last years. Um so I'll be finishing my second term on the board in December.

J: Okay, how about like AOTA or um other organizations like that you have had other than the basic membership?

M: No I haven't. you know um when you know are state president you sit on a group of state presidents at AOTA. You know, I belong to the hand therapy association but I've never really gotten into that from a leadership standpoint. Um lymphedema lana as well. Um so no I don't think so.

J: Okay, what has being an OT meant to you?

M: Well you know I think if you looked back on my career I think that one of the things that it has given me is an opportunity for um variety and opportunity for learning and on going development. And I think what was always interesting to me. and I really enjoyed kind of attaining, I have a lot of certifications. And I always enjoyed learning the different aspects. Because there was a lot of aspects to life and all of the patients had a variety of needs. Um, so when I started at the rehab unit you know I kind of dived into TBI and you went through driving and just kind of you know because I wanted to know that and I wanted to kind of um bring it as a center of excellence to ND.

J: When did you decide to be an OT?

M: Well, probably late in high school and um you know these stories always sound a little bit simplistic. But um, my mom and my sister were nurses and I really didn't want to be a nurse I didn't think. And I had candy striped [laughter] you don't even know what a candy striper is do you? [laughter] but that was a long time ago we were volunteers in the hospital and you actually wore a little candy stripe pink and white striped apron. And so I volunteered at the hospital and

really didn't want to be a PT because at that point it was a lot of walking and exercise of the legs and what not. Um and in high school my grandma died and I just thought. You know I spent a lot of time with her and I thought I'd want to do something where I could teach people to do something for themselves. So I was kind of crafty and again when I was in school we did a lot of crafts.

J: Yep.

M: That was part of it. So it seemed to fit.

J: So what you're saying is that you just kind of found out about the profession kind of volunteering through the hospital back when you were high school age?

M: Mhmm,

J: And then going off how you were saying how it was like really crafty, how have you seen the profession evolving over time as you've been practicing and describe the profession as you see it now?

M: Well, yeah so you know my first job out of school wasn't here so I worked 13 years in the community setting before I came to the hospital rehab type practice. And at that point in 89 they were in the rehab just kind of stepping or moving away from you know having people do things you know like a project. And so it was kind of interesting um which you know I think the medical payment was reducing people were having fewer, you know lesser day stays. And we had to move on quickly you know as far as attaining kind of those other skills and um so there were conversations amongst us as far you can't do just exercise. You know, I mean and really there was a little bit of a struggle with younger therapists coming in and saying you know when you said to them cause I was the supervisor you know I'd say how did they do at the store. And that was kind of. I didn't take them to the store. Well you should take them to the store. Well I

don't know how to take them to the store, you know, I mean kind of again it was a new learning skill. So um but yeah when I went to school we spent a lot of time in crafts. And you know we kind of had fun with it really. However, you know part of that was and I'm not sure realize that was it was a very structured paper that went with it that tell me which muscles were used and tell me what kind of other body skills do they have to have. And it was a task analysis. So later on I don't remember exactly when this was but one of the professors asked if I would do some side work. And just do all the task analysis for papers you know. And that was kind of neat because I enjoyed that.

J: So now we just want to look at the context of like your practice setting around the time when you graduated. What was happening in the world, different social, political, economic, educational or family events that were kind of happening for you around that time period?

M: Well when I graduated my very first job was [laughter] um I was hired by a nursing home in Fargo to set up an OT department, they had never had one. They knew that they should have one and it was at the time when Medicare was starting to kind of value that therapy component and um so I know in school when I graduated that the school said you know a new grad should never do that. they wouldn't have the skills, whatever. It was a for profit nursing home and so within after about a year they said we have another one would you do another one? And I was kind of okay with that I was the only OT of course and I could walk down the halls and talk to the nurses and got to know everybody and got to say for this patient you know this what we could do. And really at that point it was um patients were starting to come in for um for post rehab care. You know going home again and I was invited to sit on the first utilization review committee as an OT so that was pretty neat. Um I think those committees were just starting to come into being. And I got to kind of speak and advocate for services or length of stay or whatever. The other fun

thing that I though was fun is that um again having no therapy in there I picked out long term residents who um were not cognitively impaired but physically impaired and pulled them and asked to have a separate dining room for them. And um you know they really felt I think respected. And I think everybody understood then that you know that they could have um that separate environment and dining space would mean something to them you know. So anyway I went on and did the other one. Interestingly then um I left Fargo and got married and whatnot and went to Denver and looked for jobs. And socioeconomic indication of the times, I don't think that Denver needed any OT's because I got offered two jobs. One was for thumbs in hand therapy and they wanted somebody who really knew thumbs and it post-mastectomy care.

J: Hmm.

M: And it just didn't interest me and I just didn't take those jobs and then we didn't stay in Denver very long. It was tough to get a job.

J: Interesting it's a lot different from now.

M: Yes, yes it is, I really wasn't interested in peds and I didn't want to do schools and um I wasn't I guess interested in diving into huge Denver hospitals but that all that was open at that point.

J: Now can you reflect on your personal growth and professional development?

M: [laughter] Give me a hint um professional growth and personal development.

J: Yeah what do you see as your personal accomplishments like that have impacted your OT practice?

M: Well um I guess one of the things that I learned early on um when I took the job here at the rehab was that they said you know we need somebody to do hands and I said okay I can do hands. [laughing] that's probably not the easiest thing to take on you know but yep okay I can

do that. and so as long as I had some time and some mentoring and some classes. I mean I was up to learn it and I did. And I was probably the second one in the state to be certified. Um and it was very interesting to me and I liked it and then actually as we treated breast cancer ladies that came to us with very large arms. Another hand therapist and I said there has to be something we can do about this and we started looking and came upon. And at that point lymphedema treatment was just coming to the forefront and worked with the oncologist and I actually had to write a business plan to develop that service here. And they agreed and sent us for training and the two of us came back and it certainly has taken off since then cause I think we have more than 20 certified lymphedema therapists here. And I still think that is a challenging area and I've always appreciated that. so um but also um so I was upstairs in rehab and went to hands and as a supervisor and then I came down to outreach. So outreach is that therapy component that we went out to the region and we have traveling therapists. And again kind of driven by socioeconomic times when you think about it because that's when PPS reads went in for long term care. And when OT, PT, and Speech had to work together. So before that everyone was kind of just paid as was. Well they changed the system and low and behold minutes were shared and that's how the payment was so OT PT Speech worked together and I thought that would be a great opportunity for a different model. So I stepped out and went to outreach. And again found a different business model and very challenging but got to work with the three disciplines and so forth. And then from there I stepped out of that because I worked with the regional hospitals that they asked me to be a regional relations person.

J: Just going back to where you said you found out about the lymphedema. The internet is a lot more substantial than it was you know even 10, 20 years ago. How did you guys as like a

facility find out about something like that? Was that through like the journals or conferences you attended?

M: Wow how do you suppose we found out about that. I would imagine it would have been through the hand therapy sections you know that became available. One thing I always gravitated toward were the patients that were most involved. So a burn patient you know one time I flew down to Hennepin and went through the burn treatment center and flew back with the patient. And I guess I was never kind of afraid to do that. and so anyway in that whole learning process I learned to measure for garments and got my garment certification, fitting and what not and so I think from there it went to lymphedema. I think the outpatient spot where we sell garments kind of asked for some help too. So you know you put that together with the resources available. You're right, I mean today you'd look on the internet and you'd get that information I guess.

J: Then just looking back at your career was there something you'd like to do that you weren't able to accomplish?

M: I'd like to do that I wasn't able to accomplish? Not sure that there is.

J: What has been one of your best memories of being an OT?

M: When you say best memories you know there is a couple things. One of the things is that over time I learned to advocate for the profession. So, I learned to work with like BlueCross blue shield and have them understand what their payment policies meant and give them examples and work with them so that they would consider changing those policies toward therapy. And with another gal in NDOTA and again that how those relationships work. We put together the peer review system so.

M: Do you know what that is? Have you heard about that?

P: With NDOTA can you explain a little bit?

M: Sure, NDOTA is the membership organization and there was a time when workforce safety and ND BlueCross came to us and said we need outside peer reviewers. So, if we deny this claim and somebody would say that this is not right or you're not an OT and you don't know what you're talking about. We need an outside reviewer to review the case and tell us you know that yes, the claim is right as paid or no BlueCross should pay some more and give more sessions. And so again a neat learning opportunity but we met with some other people in MN who had a system set up and we set that up under NDOTA. I went on to be a peer reviewer and did most the hands and so forth. And again, a great learning opportunity and a great opportunity to turn around to the OT's in the state and do some workshops and say this is how this looks in your documentation, this is why you're not getting paid and this is what you need and so forth. That's not always a favorite thing for OT's to think about. I think on the patient side I think the patients that I took care of that were breast cancer patients and the burn patients is probably what I enjoyed the most as a therapist

J: What has been one of the most challenging experiences you've faces as being an OT?

M: You know probably learning to advocate and it was good experience but it was really quite foreign. So even before I was on the practice board when we wanted to change the OT licensure law. to understand how to go to a legislative committee to advocate for those changes and explain to them what was needed was kind of a .. the patient stuff was probably easier than getting outside.

J: Alright and that's all I have.

P: Alright, so we'd like to just get a general understanding about what your educational experiences were like. Could you just start out describe your education a little bit, so you graduated in 1975, could you just describe maybe like the class size or the theoretical models you were studying and faculty experiences?

M: Oh, how many were in that class? About 40 I would imagine. I don't know. I don't know if it's a whole lot different from what you have now. I would say I guess certainly I don't know if you've ever heard about the buildings that we went to.

P: No.

M: And we had interesting professors. And Amy Lind was the head of the program and she was Canadian. Neat lady. And then, you know, there was just kind of like 3 right? I mean that's all there was, and there was one that taught all the crafts, and there was one that was phys dys gal, and she was pretty much by the book. And I remember very well kind of that experience where you put on the gloves and you'd try to have – and she invited us over to her house – and try to eat. We all had a disability and tried to eat. But the building that OT was in was left over from WW2 and so it was a Quonset and it was kind of back – kind of to the side and back of rehab. And it was an old wood building, and that was kind of neat. We were kind of the only ones in there. There was kind of, there was woodworking shop and there was a printing press, we had to print. And I did, I did a three day rotation at the psych unit in Fargo at old St. Luke's, which is Meritcare now and they had the woodshop up on the psych floor, so that's very much reality. We had to go out to a nursing home and work the loom, and that was like, everybody thought "oh, that's going to be just awful," but it was kind of a job that the nursing home needed then I don't know exactly how they – I mean this is a big floor loom, I don't know if you've ever even seen one. And then, I have something for you, but I was looking for pictures because you asked about

pictures, but I don't really have any pictures, but I found this. We had a two harness loom, it says it's a four way loom, but it's, it has two harnesses, probably doesn't mean anything to you either. But this is how to adapt the loom for a physical disability. So you take this back to Gail and she can put it in the archives. It's from the Scottish Association of Occupational Therapists.

P: You don't want this back?

M: No I don't. I don't think anybody would appreciate it here at all. And that's why I have it. It was 1954 when it was printed.

P: Wow.

M: Yeah, so you know, and that's kind of how the crafts went is not only did you have to know how to make it work, but how were you going to make it advantageous for a stroke patient and what would you be able to do if they were blind. There was a COTA here that had worked with the School for the Blind. We contracted with them and she did mobility training and I always felt that she shared some really good skills with me, you know?

P: Kind of going off of that can you maybe describe how you see the impact of the development of OT and OTA programs specifically and the collaboration between those two professions?

M: I would say over the years I have always been a very strong advocate for the COTA. I think that it's really important to have that understanding and have that partnership and an OTR and a COTA that work well together can really accomplish a lot. And I think it's always wise to have, you know when you're working with somebody, especially if it's long-term or in depth, it's always nice to have two people and to share that caseload. I've done workshops on OTR/COTA partnership and how that should work, even in the documentation of it and the responsibility, I think is kind of a problem. So even on the board we went through and actually wrote out examples of, in the North Dakota licensure you have to sign for a COTA, right? So, they know

that they have somebody to partner with. And I don't think everybody understands, OTs and OTAs, how that partnership should work. I don't know what's going to happen as you kind of go down the track of a four year COTA. You know, maybe I'm too old school, but I'm not sure that that's, I mean is it necessary?

P: That's perfect, and it kind of leads into the next question I was going to ask that's kind of, just your general thoughts on the 4-year COTA degree and the ACOTE, I don't know if you've heard, but they've indicated that by 2027 all OTRs will need the doctoral level degree. Could you share your thoughts on that, maybe some positives that may come from that as well as some negatives?

M: Yeah, I guess I wouldn't agree with that. I think for, we need OTs in the field, right? We need OTs to be treating people. And if everybody's going to be a doctoral level it's going to be pretty expensive to get that education. And I'm not sure what is added for the patient delivery. And health care is too expensive now. We can't pay really big salaries to everybody, so I'm not sure what we're gaining in the end. Should we have doctoral levels, should somebody be doing research, yeah maybe. But to chase after it just because the PTs went to a doctoral level, I think that, I don't know. Did we have to as a profession? Yeah, I don't know, I mean maybe. I know the arguments but I think it's the wrong way to go, personally.

P: And then have you seen a shift in the development of OT models and frames of reference from the time you graduated to now or is it pretty similar to around the time you graduated?

M: You know the biggest shift I think I've seen is that, I can't tell you exactly when, probably in the 90s, and I would credit Jan Stube with this, but that Canadian Model of Function, you know. We had a pretty, pretty cut and dry look at phys dys. It was just pretty straight forward, you know. And you had the protocols and that's what you did. And to get that leap to step back and

look at function was a change and Jan Stube, bless her heart, would come and those of us working in the field for so long presented this and talked about it. We actually hired an OTR from Canada, and we really appreciated her different frame of reference. We could just tell, you know it was like a different school. And I think a part of that is coming from socialized medicine, is because, I mean, she said "well what are you worried about"? I mean we're not going to get paid for it, and she was like, "Woah! Really? Well we should really do this!" Well yeah, we should, but we're not going to have time to do that, so it was a learning experience for her too, unfortunately. You know, should we go back to that, should we go back to it, yeah I think it'll come back around.

P: So next we'll do a little card sort activity. So we've got these different, so basically we reviewed a series of articles looking at the values and beliefs across time of OT. These are some of the big things that we found in the articles of the major values and beliefs of OT. If you could just prioritize these cards in terms of enhancing your professional practice and development, so yeah basically prioritize them about what's most important to you for professional development from top to bottom.

M: Of mine, or just everybody's? What's been important to me?

P: Yes.

M: Oh, boy. These are interesting.

P: Yeah, you've got quite a few to look through there. Or you could group it into sections too.

M: Well, OK. So specialty certification obviously has been a big deal to me because to get your CHT we worked really hard at it, and it was something I spent a lot of time at. It was really important, so I guess that would be really close to the top. The other thing I guess I haven't mentioned is one of the things that kind of became my, a strongpoint or I kind of let out was

understanding Medicare regs. So as time went along, I was the geek that could understand the Medicare regs and kind of put it into practice. And, you know you all have your specialties and it just kind of made sense to me so this legislation and Medicare stuff because you had to be able to explain it to people, nurses, administrators, whatever. Licensure just kind of goes with that. You know, health care team, you need, everybody needs to know what you are. If the team doesn't respect you and what you do and how you enter into that patient care, you're kind of dead in the water, so then you're not very good to patients anyway. And then the rest of this stuff on the treatment side, I feel like that's kind of the professional side. On the treatment side I'd have to put occupation up here. Because I've really, when I think back on the patients I had, it was really important that I understood what they did or what they wanted to do. So I had a patient and I seemed to get the patients that nobody really wanted to take. As supervisors, that's what happens. And you know, people would just, you don't pick your patients, you just got them assigned to you, like here's your chart, you know? Well, it was an orthopedic surgeon, newly retired that had a mild stroke. Not a very happy man, right? Came in as an outpatient. And, I just thought "Yeah, what are you going to do with that"? So spent enough time with him and got him kind of, again, got COTAs and aids to kind of get him comfortable in the milieu. I had him showing me how to tie surgical knows. Now was he ever going to tie surgical knots again? No. But that's what was important to him. And to work with both hands and be able to tie those surgical knots again, and then he said "Yeah I'm done". And I said "yeah I think you are too". I mean that's what was important to him. So I think if you can understand occupation you're going to meet the needs of your patients. Arts and crafts, I think, I'm going to put that up there because that's just your medium. Doesn't matter if it's arts and crafts, doesn't matter what it is, whether it's tying a surgical knot or whatever. And then you're going to have to have activity analysis

because you're going to know why you're doing it. And as you can probably tell, I was the one when they had students. I mean I actually had a student that got me as a supervisor, went back to school, and said "there's no way I'm going to pass". And the school said "Oh no, no, no, you're going to go back". And, you know, I don't think I was any tougher than anyone else, but I think I asked some questions and said, "What are you doing? Why are you doing that? You can't do that". And then, so she just got over it, of course. But you have to know why you're doing it. Adaptive equipment, I'm a sewer, so again a COTA and I, my favorite COTA, we could sew and come up with and make things and what not, so that's important. You know, technology I guess was one of those things that was coming into being. There was another OTR that did much more with the programs, the very slow programs that you put a TBI patient in front of a computer just really didn't turn my crank. And continuing education, I suppose that's part of certification. How's that?

P: That's perfect. Thank you. We'll leave those sitting there for awhile for Jared to get down. So now we'll move on. North Dakota is considered to be a rural state. So how did this influence your practice decisions, and impact the care you were able to provide? I mean, obviously Grand Forks is a bigger city but still a rural area in general. So if you could just explain how these influenced your decisions and care.

M: The thing about Grand Forks is that 50% of the patients that come in to the acute hospital don't live in Grand Forks/East Grand Forks. So we're really seeing a lot of very rural patients. And that's kind of hinges on, so as an outpatient therapist in hands and what not, these patients would travel a long way to get here. So when they set aside this separate unit of outreach therapy, I just thought it was great that we could go out and see patients wherever they were, in their home or what not. It just made so much more sense to me and I never worked home health,

that's probably one of those things that I probably would have liked. But to go out to these rural communities that didn't have, because there just wasn't a therapist. Long ago, we would have somebody in the rehab and we'd try to refer them out for therapy. There was nobody to send them to. Now there is, I think we've got the rural area pretty well saturated, but I suppose rural North Dakota/Minnesota there just isn't an OT. I forgot the question.

P: No that's perfect.

M: OK.

P: And can you maybe talk about how the rural landscape influenced your involvement in professional organizations, like NDOTA?

M: Well, North Dakota isn't that big, right? And it became apparent that there were OTs and COTAs working in very small places, very independently, very isolated. They really needed to be connected. And I think we really tried to have more of that network and what not. I'm not sure we succeeded a great deal, you know. The other thing that kind of happens in North Dakota, believe it or not, I don't know what it's like in larger states, but you have OTs in schools, and they're like the school OTs, they just are kind of a breed unto themselves, and you have a hard time linking some of those to acute care. The NICU therapists, I mean man they are sunk into that, and so you know in NDOTA we, our biggest deal was put on this yearly education thing. And there wasn't hardly any education in North Dakota a long time ago, so this was the big deal. And a lot of therapists came and it was hard to find something that would go across the continuum of all those different practice areas. When I went to school it was like phys dys and psych, you know? And I graduated and I was going into psych, I just knew it. And I never did go into psych.

P: That's funny. So now can you imagine that I'm a family member who's considering pursuing a degree in OT. What advice would you give me, and what are some positives or drawbacks of this degree? Of being an OT.

M: Well, if you're going to go into OT, you should know very much about what it's about. And once having made that decision, I think it'd be a great decision because you'd have a good opportunity to change and to morph according to your interests in the landscape of where you are. And sometimes that is a big determinant of what happens to you in life. So it gives you a chance to expand further, work with great people in different teams. Health care is, seems a little unstable at the moment, but it's a good job. And so I'd encourage you to do that.

P: Can you think of any drawbacks to pursuing this degree, or not?

M: Persevere, everything school is hard, but if we got through our junior year, we're doing good. And we didn't lose too many kids out of our grade. But going into it we knew that it was no joke. I mean you buckled down and you had to do it. And so we did.

P: Just a couple more questions here. Can you tell us about some factors that facilitated and supported the progression of your career over time? Like opportunities.

M: Well, you know, whenever you think about that you think about your supervisors or your one-ups. Even if that first nursing home when, kind of on blind faith they hired me not knowing a clue of what I would do or what would happen, you know? Very supportive, kind of gave me space and I think that's really important for somebody to learn and to grow is to go ahead and give them space. So even if you worked in a large therapy team, and you came and said "you know, I'm kind of interested in this", I would hope your supervisor would say, "OK. I'll give you this many dollars, this many hours. What would you do with it and where would you go with it"? And I think when it came to the rehab, it was pretty much the same thing. I mean, you know

maybe I could talk a good story. But I say if you just buy this, you know, we could do this with it. Or we could develop this, or we could put together these opportunities and I don't think I would have done well stymied. So to know yourself and know where you would blossom is important. Acute setting, and I suppose I had opportunities to work on acute side, but very short-term patients, very regimented probably isn't, wouldn't have been my forte.

P: Can you maybe, so you just talked about some opportunities. Could you talk about some barriers that might have challenged the progression or your career?

M: Well, probably being in a rural setting. So if I would have worked in Minneapolis I probably would have gone and looked for a job in a burn unit. Because I really enjoyed that. It was very intense, and it was kind of tough work. So, as far as barriers, would be probably be the, I don't want to say lack of opportunities but kind of, you know?

P: Sure. I have a question kind of specifically about the burn unit. So we just had a hand therapist come in and talk to us about some people she had worked with who had been burn victims, so did you find a relationship between burn patients and hand therapy or were they kind of separate?

M: Nope, they were the same. So the patients that I had were upper extremity burn patients, so yeah. So badly burned. So they may, they had burns but these fingers fused, and this one's fused, and this one's amputated, and you just were really looking for functional grip. I had a couple farm patients where hands went through rollers and one where it was degloved. Young man, 20 years old and got his shirt caught and it just ripped all the skin back. So those kind of patients you just get, I don't want to say get close to, but I mean I certainly enjoyed them. There was somebody on the news the other night that made me think. That gal that was at a baseball game and she caught her ring on the fence and she tore off her finger. And it reminded me that I had

two patients, ladies, one of them had horses, and she got the rope caught around her finger and the horse took off and took off the end of her finger, just "pop". Just like that. And I saw her in a rural area, went out in outreach and saw her, and she was dealing with it pretty well, not missing the end of the finger too much., Another lady, again, had the finger, or rope around the finger, and her husband took off in the boat and took the end of her finger with it. And it wasn't too long. She was showing up at 8:30 appointments in the morning drunk. I mean, she just was not dealing with this at all. And so, what that does to your life, I think our hands are so important to us and so expressive. So, that's where you kind of get into that's hand therapy? Yeah, let me tell you, it was a lot of psych. It just was because there's a lot of pain, and there's a lot of healing that needs to go on totally.

P: And, last question, what personal characteristics have positively impacted your career, and maybe negatively as well?

M: Say that again.

P: So what personal characteristics have positively impacted your career and possibly negatively?

M: Oh boy. Well, I think I maybe probably have a sense of how it should be. And when, because of policy or the way that things need to be, or the financial situation that doesn't happen, that's kind of a tough thing for me to swallow. On the positive side, that's probably why I stepped into an advocacy role. If Blue Cross wasn't going to pay for it or medical assistance wasn't going to…medical assistance doesn't pay for garments. And I had a patient once that, psych, set herself on fire. But came to me because she needed a garment for the burns on her neck. And medical assistance wasn't going to pay for it. Well, that just drove me crazy. I mean, I was writing letters and calling senators and everything to get this thing paid for, because that just wasn't right, you

know? I just don't think they understood what you're saying to this patient. So I guess that's a plus and a negative, right?

P: Yeah, that's great. Well, I don't have any questions. Do you have any that you're wanting to follow up on?

J: No, I think that's it, you did a really good job explaining the questions that we had.

M: Good.

J: Kind of took the need away of the probing questions to ask for more.

M: Oh, sure. OK.

P: Yeah, so thank you so much for being willing to meet with us and take time out of your day.

M: Yup.

P: I guess this wraps up our session.

M: Good.

Further insights from Ms. Waind post-interview via email:

In 1974-1975 I did my first clinical rotations at the Rehab – or UND's Medical Center Rehabilitation Hospital. The new building was just opening on the new Medical Park Campus. United Hospital had not yet been built. The Rehab was an 88 bed Rehab facility and served the whole area for inpatient and outpatient Rehab needs. The top floor was mostly children and these children stayed for weeks. Many in hip-spica casts or those learning to deal with spina bifida.

Several of the rooms were wards or multibed units. At that time, it wouldn't be unusual to have 8 spinal cord injuries of various levels. MCRH was one of the few who featured Halo casting with Neurosurgery to stabilize a spine. Initially, the Halo was casted on with plaster and remained in place for 6-8 weeks. Those patients, and their caregivers, were equally happy to get that body

cast removed. As a student in my Level II fieldwork at another facility, a patient with a Halo casted on went into cardiac arrest in OT. The patient died because of the time it took to saw off the body cast for treatment. What a harrowing experience for a student to deal with.

Other care that kept patients as inpatients was Rheumatoid Arthritis, Back patients, and total joints. Many of these patients stayed for weeks. Overtime, the Rehab inpatient unit was downsized to 40 beds and 1 floor. Much of the treatment and care was moved to other tertiary care centers that started Rehab units in Bismarck and Fargo. The Medical Center Rehab Hospital was sold by UND to United Hospital in Grand Forks, which later was renamed Altru Hospital.

In the mid-90s, OT took on a new face at the Rehab with “Easy Street”. A functional group of facades and revamped spaces that allowed therapists to take their patients “home” or to the grocery store or in and out of a car. All these environments helped us give perspective to Rehab patients and saved us from the inclement weather of North Dakota.